RCWH.0000254765 IP5-00174421
Master PRIYANSHU BOSE
14-07-2013 12 Y 10 M 14 D (M)
Dr. HARISH JAYARAM

Patient

SURGERY DETAILS

Date : 28/5/26

Patient Name: Mast. Priyanshu Bose Date of Birth: 14/7/2013 Age: 12years

Gender: Male Ward : OT UHID No.: RCWH-0000254765

Date of Surgery: 28/5/26 ☐ OT -1 ☑ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Mucosectomy

Time in : 9:30am Time Out : 10:10am

		NAME	AMOUNT
1.	Surgeon	: Dr Harish Jayaram	
2.	Anaesthetist	: DR. Durga Bhavani	
3.	Assistant Surgeon	:	
4.	OT Technician	: Neshanth	
5.	Circulating Nurse	: Jyothe	
6.	Assistant Nurse	: Thejas	

Special Equipment: ☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator ☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa ☐ Neuro Cusa ☐ Others ....

Signature of the Surgeon (signed) Signature of Circulating Nurse Jyothe

Order No: 9630992 Order by: Jyothe.

Docu. No. : RCHBH/FRM/GENERAL/114

MTP - Priyansh

RCWH.0000254765 IP5-00174421
Master PRIYANSHU BOSE
14-07-2013 12 Y 10 M 14 D (M)
Dr. HARISH JAYARAM

Excision of mucosal prolape

Rainbow® Children's Hospital
It takes a lot to treat the little.

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

CONSUMABLES OF OT

Technician : Nishanth Date : 28/5/26 Time : 8:30 Am

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube 5, 5, 5, 6, 6.5	1+1+1	—	Major Pack drop	1	1	Inj Vit.K		
LMA 2/2/3 (1½)	1+1	01	Sutures 9915	2	—	Cord Clamp		
ECG leads : A / P / N	5	03	2303, 2304	2+2	—	Suction Catheter		
HME filter : A / P / N	1	01	2437	2	—	Feeding Tube		
Syringes : 10 cc	10	10	prolene 2, 3, 4	2+2	—	Vaccum Suction Set		
05 cc	10	6	Gloves			Surgical Gloves		
02 cc	10	8	6, 6½, 7, 7½	2+2+2	02	Gauze Pack		
01 cc	5	—	PF 6, 6½, 7½	2+2+2	—	Syringe 1ml / 2ml		
Cautery plate A / P / N	1	—	Surgical blade 11+15	1+1	01	Surgical Blade # 20		
IV set	1	01	NG tube			Koochies (S)		
RL	1	01	Cautery pencil	1	—	NS 500 ml	1	—
NS / 10ml / 100ml / 500ml / 1000ml	5+1	01	Koochies Adult (M)	01	01	10cc, 5cc	2+2	—
minispike	1	01	Ointments			jelly	1	—
O2 mask (A)	1	01	Suction Catheter					
Fentanyl	1	01	Cap, Mask	5/5	3,3	1		
Morphine			Gauze Pack (N)+R	3+3	02			
Ketamine			Mop Pack	1	—			
Propofol	3	02	Steristrip					
Rocuronium	1	—	Underpad	1	1			
Glycopyrolate	1	01	Draw sheet	1	1			
Myopyrolate	1	01	Abgel					
Ondansetron	1	—	Foleys catheter					
Pencan 25g/ Spinal Needle 22	1+1	—	Urobag			Gauze	3	02
Bupivacaine 0.25%	1	—	Chest Drainage Catheter			Glovyal	4	02
Bupivacaine 0.25%(Heavy)	1	—	Romodrain bag			Dexmed	1	—
Antibiotics 10x2%	1	—	Bandage			Dexa + Tranexa	1+1	—
Loupem	1	01	Tegaderm			50C+pmtone	1+1	—
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set	1	—			
Justin : 12.5 mg / 25mg / 100mg	1+2	—	Plastic Bed Sheet	1	01			
Tab. Misoprost : 200mg			Betadine Solution	1	01			
vacuum set	1	01	Microshield	1	—			
oral airway 1, 2	1+1	—	Cotton Balls	1	01			
Bway (10ml+10cc)	1+1	01	Latex Gloves	10P	10P			
Loucannula 20, 18	1+1	—	Ramdione Scrub					
Nasal airway 22, 24	1+1	01	Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 9630966 Ordered by :

Doc. No. : RCH / FRM / GENERAL / 125

Rainbow Children's Hospital | BirthRight Rainbow

Rainbow Children's Hospital - Banjara Hills

8-2-120/103/1,2,3,4 and 5,Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad ,Telangana, India ,500034.
TEL NO :+91-40-4466 5555
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP5-00174421 **Admit Date** : 28-May-2026 **Admit Time** : 07:34 AM **UHID** : RCWH.0000254765

Patient Details :

Patient Name	: Master PRIYANSHU BOSE	**Age**	: 12 Y 10 M 14 D
Guardian	: Mr AMIT BOSE	**DOB**	: 14-07-2013
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: FLAT NO 401,,SURYA ABODE , RAOD NO - 6, ANJANEYA NAGAR, MOOSAPET, Kukatpally Hyderabad Telangana INDIA 500072	**Phone No**	: 9949071977/ 9963663331
		E-mail	: NOMAIL@GMAIL.COM

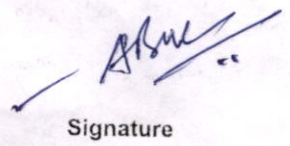
Admission Details :

Bed Type : DAY CARE **Bed No** : PRE OP 405 **Ward Name** : 4F-OT COMPLEX

Room No : PRE OP 405 **Admission Type** : First Visit

Contact Details :

Name	: Mr AMIT BOSE	**Relationship**	: Father
Contact Address	: FLAT NO 401,,SURYA ABODE , RAOD NO - 6,ANJANEYA NAGAR, MOOSAPET, Kukatpally Hyderabad Telangana INDIA 500072	**Phone No**	: 9949071977



Signature

Doctor Details :

Doctor Name	: Dr. HARISH JAYARAM	**Specialisation**	: PEDIATRIC SURGERY
Referral Doctor	: Self	**Phone No**	:
Co-Consultant	:		

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash **Payor Name** : SELFPAY

RCWH.0000254765 IP5-00174421
Master PRIYANSHU BOSE
14-07-2013 12 Y 10 M 14 D (M)
Dr. HARISH JAYARAM

Patie

Rainbow® Children's Hospital
It takes a lot to treat the little.

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

OPERATION THEATER NOTES

Patient's Name : Mast. Priyanshu Bose Age : 12year Gender : ☑ Male ☐ Female

UHID No.: RCWH-0000254765 Weight : 54.4kg Height : —

Surgeon : Dr. Harish Jayaram		Asst. Surgeon : —
Anesthetist : Dr. Durga	OT Nurse: Thejas / Jyothi	OT Technician: Nishanth

Pre-Operative Diagnosis: High ARM (all stages complete) c̄ mucosal prolap

Surgical Procedure : Mucosectomy

Indications for Surgery : 1) persistent mucosal bleed
2) incontinence

Date : 28/5/26	Start Time : 9.46am	End Time : 9.53am

Pre Operative Preparations:

5% Betadine

Post Operative Diagnosis: Mucosal prolapse in a k/c/o anorectal malformation

Peri-Operative Complications:

Operation Notes: Findings - mucosal prolapse (+)
- anal orifice narrow
- mucosectomy & anal dilatation done.

Steps ① Lithotomy position, painted & draped
② prolapsing mucosa excised with bipolar cautery.
③ anal dilatation done upto 12mm dilator.

[signature] Parale

Amount of Blood Loss: —— | Blood Transfused (in ML) ——

Name and Number of Surgical Specimen sent for examination: ——

Peri-Operative Complications:

DAY CARE

1. Tab. PARACETMOL 500mg PO THRICE DAILY for 5 days then SOS for pain
2. MEGAL-HEAL OINTMENT L/A for 2weeks
3. SITZ BATH c̄ 5% betadine THRICE DAILY for 2weeks.

Review after days in OPD c̄ Dr. Harish Jayaram Sir

Name of the Surgeon: Dr Harish

Signature of the Surgeon: [signature]

Date & Time: 28/5/24 10:50am

Rainbow® Children's Hospital
It takes a lot to treat the little.

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

ACTIVITY RECORD FOR BILLING

Name : ______________________________

UHID No. : Priyanshu IP No : RCWH.0000254765 IP5-00174421 Dept : __________

Master PRIYANSHU BOSE
14-07-2013 12 Y 10 M 14 D (M)
Dr. HARISH JAYARAM

Date of Admission: __________ T ...arge : __________ Time: __________

Room / Bed No : __________ Ward : __________ Billable bed type : ______________

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
28/05/26	7:30am	ER	OT	Aruna
28/5/26	12PM	OT	Billing	[signature]

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
28/5/26	CBP	26054116	[signature]

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
28/5/26	DJ placement	1	9630670	[signature]
	PAC op			

ANY OTHER INFORMATION

....

....

....

....

....

....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

PEDIATRIC IN-PATIENT MEDICAL RECORD

RCWH.0000254765 IP5-00174421
Master PRIYANSHU BOSE
14-07-2013 12 Y 10 M 14 D (M)
Dr. HARISH JAYARAM

Patient Name: ______________________

UHID ID: ______________________

Department: ______________________

Consultant: ______________________

ʟCWH.0000254765 IP5-00174421
laster PRIYANSHU BOSE
4-07-2013 12 Y 10 M 14 D (M)
lr. HARISH JAYARAM

Pediatric Multiorgan History & Physical Examination

Rainbow Children's Hospital
It takes a lot to treat the little

Name : Priyanshu Bose. Age/Sex 12 Y

Information given by: Relationship

Chief Presenting Complaints & Duration (Chronologically)

f/v High Anorectal Malformation
All stages completed
now p/w partial mucosal prolapse of
pull through bowel.
C/o recurrent bleeding P/R.

History of present illness :

Child is k/c/o ~~intermediate~~ High Ano-rectal anomaly
diagnosed at birth.
Underwent colostomy on 4/7/2013
f/B posterior sagittal ano-recto plasty (PSARP)
on 25th Feb 2014.

Currently ~~k/c/o~~ c/o recurrent episode of bleeding P/R
a/w occassional soiling of stools
No c/o stool (or) urine incontinence.

No c/o fever / vomiting / abd. disten /
colicky abdominal pain.

RCWH.0000254765 IP5-00174421
Master PRIYANSHU BOSE
4-07-2013 12 Y 10 M 14 D (M)
Dr. HARISH JAYARAM

Pediatric Multiorgan History & Physical Examination

Past History : (Including details of any previous investigation or treatment)

K/c/o single (R) kidney (Left renal agenesis)

H/o Adenotonsillectomy in 2020

Birth & Neonatal History:

Term | El. LSCS | CIAB

Detected c single kidney & High anorectal malformation.

Birth & Socio Economic History:

About Father :

About Mother :

Any additional Information :

Developmental History :

Achieved all milestones acc to age.

Immunization History :

Up to date c immunized

(P.T.O.)

CWH.0000254765 IP5-00174421
aster PRIYANSHU BOSE
-07-2013 12 Y 10 M 14 D (M)
r. HARISH JAYARAM

Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) ~~168~~ (Centile) Height (cms): 168 (Centile)

Weight (kgs)) 51.57 (Centile)

On Examination :

Temperature : 98.4°F Pulse Rate : 68bpm B.P. 110/70 SPO2 99% - RA

Resp.rate and type of breathing : 22cycles/min

Rash —

Lymphadenopathy —

Oedema : —

Allergies (if any): NKDA

Respiratory System :

Inspection (any s/o distress) : No

Air entry & breath sounds : BAE (+) clear

Any addes sounds : —

Relevant data from outside (Chest X-Ray, ABG,etc.,) —

Cardiovascular System :

Inspection of procordium :

Heart Sounds : S1+S2+

Any murmur : no murmur

Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) :

Per Abdomen :

Inspection soft

Palpation : non tender, no organomegaly

Ausculation : BS (+)

Spine : External Genitelia : Normal

Relevant data from outside (CT, USG etc.,)

CWH.0000254765 IP5-00174421
laster PRIYANSHU BOSE
4-07-2013 12 Y 10 M 14 D (M)
r. HARISH JAYARAM

Patient Sticker

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : 15/15

Cranial Nerves : normal

Motor System:

Nutriton : well nourished

Tone: normal Power 5/5

Co-ordinator :

Posture :

Involuntary Movements : — Not

Reflexes : normal

DTR **Superficials:**

Plantars WNL

Sensory System :

WNL

Bladder / Bowel : Continent

Clinical Summary & Diagnostic:

P/o High ano rectal malformation
All stages complete.
~~now~~ P/w partial mucosal prolapse of pull through bowel

(P.T.O.)

RCWH.0000254765 IP5-00174421
Master PRIYANSHU BOSE
14-07-2013 12 Y 10 M 14 D (M)
Dr. HARISH JAYARAM

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment : To stop bleeding P/R episode
To improve symptom of stool soiling

Planned Labs:

CBP

Planned Management

Excision of mucosal prolapse

Signature of the Doctor: [signature]

Name of the Doctor: Dr. Nikhil

Date & Time: 28/5/26 11:30am

Signature of the Consultant: [signature]

Name of the Consultant: Dr. Harish Jayaram

Date & Time: 28/5/26 10 AM

RCWH.0000254765 IP5-00174421
Master PRIYANSHU BOSE
14-07-2013 12 Y 10 M 14 D (M)
Dr. HARISH JAYARAM

Rainbow® Children's Hospital
It takes a lot to treat the little.

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PEDIATRIC ED DOCTORS ASSESSMENT (IN-PATIENTS)

Admitting Doctor : Dr. Harish Jayram
Date : 28/5/26

Type of Admission: ☑ OPD ☐ ER ☐ Referral (if referral, Doctor's Name: ....)

Start Time of Assessment: .... Weight: 54.7 kg

Allergic History: ....

Chief Complaints:
F/c/o High Anorectal malformation with all stages of repair completed
C/o - Bleeding from anal region with prolapse of anal mucosa
- Soiling of stool due to inadequate anal canal approximation

Pediatric Assessment Triangle

A Appearance - TICLS ....

B Breathing
- ☐ ↑ WOB
- ☐ ↓ WOB
- ☑ Normal
- ☐ Gasping / Apnea

C Circulation
- ☑ Normal
- ☐ Abnormal
  - Pallor ☐
  - Cyanosis ☐
  - Mottling ☐
  - Bleeding ☐

Initial Physiological Status: ☑ Stable ☐ Unstable
- Life Threatening ☐
- Non Life Threatening ☐

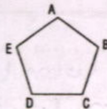
Any urgent interventions needed: ☐ Yes ☐ No
If Yes ....

Significant Past History: F/c/o High ARM → 3 stages of repair completed / Single kidney (Right) / Adenotonsillectomy 6 years back

Medication History: Nil

Relevant Investigations: USG abdomen → Non visualisation of left kidney with compensatory hypertrophy of Right kidney.

Primary Assessment



Airway
- ☑ Open
- ☐ Maintainable
- ☐ Not Maintainable

Any urgent interventions needed: ☐ Yes ☑ No
If Yes ....

Breathing

Rate: 20/min SpO$_2$ on FiO$_2$ 99% @ RA

Rhythm: Regular

Retractions: ☐ Suprasternal ☐ ICR ☐ SCR ☐ Sternal ☐ Supraclavicular ☐ Nasal Flaring

Respiratory Noises: ☐ Stridor ☐ Wheezing ☐ Grunting

Air Entry: BAE ⊕

Palpation Findings (If necessary) ....

Any urgent interventions needed: ☐ Yes ☑ No
If Yes ....

Circulation

HR: 82/min
CFT — Central / Peripheral: <3sec
Any urgent interventions needed: ☐ Yes ☐ No
If Yes ....

BP: 107/62 (77) mmHg
Pulse Volume: Central / Peripheral: Good
If in Shock: Compensated .... Hypotensive ....
Muffled Heart Sound: ☐ Yes ☑ No
Engorged Neck Veins: ☐ Yes ☑ No
Murmurs: ☐ Yes ☑ No
Liver Span: ....
ECG: ....
Any Signs of Heart Failure: ☐ Yes ☑ No

Disability

GCS: 15/15 AVPU: ....
Any urgent interventions needed: ☐ Yes ☐ No
If Yes ....
Pupils: Responsive ☑ Non-Responsive ☐
Size — Right .... Left ....
Active Seizures: ☐ Yes ☑ No Sugars: ....
Signs of Neurological compromise ....

Exposure

Temp.: 98.1°F
Any Rash: ☐ Yes ☑ No,
If yes describe the rash ....
Active bleed ....
Lacerations ☐ Abrasions ☐ bruises ☐
Describe: ....
Any urgent interventions needed: ☐ Yes ☐ No
If Yes ....

Final Physiological Status: ☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest
☐ Shock - Compensated ☐ Hypotensive ☐
☐ Cardiopulmonary Arrest ☑ Hemodynamically Stable

Secondary Assessment: Head to toe examination with positive findings: ....

Labs Planned:
~~CBP~~
~~NB~~
Dhavan 27/5/26

Treatment Planned:
1) NPO — 6am coconut water, 6:30pm solid
2) IVF: DNS @ 80ml/hr
3) Shift to OT
4) Excision of mucosal prolapse
5) Inj. Cefazolin 1gm before Procedure

Need for Oxygen: ☐ Yes ☑ No if yes Low Flow ☐ High Flow ☐ PPV ☐

Final Diagnosis with possible Differential Diagnosis (If necessary): f/c/o H/o Anorectal malformation now with mucosal prolapse

Assessment done by
Name of the Doctor: Sai
Signature: [signature]
Date & Time: 28/5/26

Sr. Doctor on Duty (If necessary)
Name of the Sr. Doctor: ....
Signature: ....
Date & Time: ....

RCWH.0000254765 IP5-00174421
Master PRIYANSHU BOSE
14-07-2013 12 Y 10 M 14 D (M)
Dr. HARISH JAYARAM

Rainbow® Children's Hospital
It takes a lot to treat the little.

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

MEDICATION RECONCILIATION FORM

Drug Allergies: .... ☑ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.
(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ER Shifted to: OT

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : [signature] Sai

Date & Time : 28/5/26 @ 7:30 am

Nurse Name & Signature: [signature]

Date & Time : 28/5/26 @ 7:50 Am

RCWH.0000254765 IP5-00174421
Master PRIYANSHU BOSE
14-07-2013 12 Y 10 M 14 D (M)
Dr. HARISH JAYARAM

Rainbow® Children's Hospital
It takes a lot to treat the little.

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

INFORMED CONSENT FOR SURGERY / PROCEDURE

Authorization By: ☐ Patient ☑ Patient Attendant

I, the undersigned do hereby agree to undergo the following surgery(s), Procedure(s) on patient / myself at Rainbow Children's Hospital. (Avoid technical terms and leave no blank space)

1 Mucosectomy

2 ....

I acknowledge the following:

1. I have been made aware of the benefits and reasons of the surgery / procedure as indicated by the clinical observations and / or diagnostics performed.
2. The benefits and risks of this surgery / procedure have been explained to me. I have also been told about the alternatives available for this surgery / procedure including the advantages and disadvantages of the alternatives.

Benefits of the Surgery(s) / Procedure(s)	Alternatives of the Surgery(s) / Procedure(s)
Removal of protruding mucosa from anus	– None –

3. As with any procedure, I am aware that risks such as blood loss, infection, cardiac arrest, anesthetic allergic reactions, paralysis, Deep Vein thrombosis (DVT), Pulmonary thromboembolism (PTE) etc may arise necessitating attention. Therefore, in addition to consenting to the performance of the above-mentioned surgery/procedure(s), I also consent and authorize the rendering of such other care and treatment as patient/my surgeon or his / her designee reasonably believes necessary should one or more of these and or other unforeseeable events occur.

Apart from the listed above, I have also been explained about the possible complications of the surgery / procedure are as follows:

a. Bleeding, infection

b.

1. I authorize Dr. Harish Jayaram and his / her team to perform the procedural sedation upon the patient / myself.
2. I recognize that the practice of medicine is as much an art as a science and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcomes.
3. I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: [signature]

Name: AMIT BOSE

Relationship with patient: Father

Date & Time: 28/05/26 @ 8am

Witness:

Signature: [signature]

Name: MAUSUMI BOSE

Date & Time: 28/05/26 @ 8am

Doctor (who is taking consent):

Signature: [signature] Name: Dr. Harish Jayaram Date 28/5/26 Time: 8 AM

Patient Sticker

Rainbow® Children's Hospital
It takes a lot to treat the little.

శస్త్రచికిత్స / ప్రొసీజర్‌కు అనుమతి పత్ర

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, రోగి/నా పైన రైన్బో చిల్డ్రెన్ హాస్పిటల్లో చేయబడబోయే క్రింది శస్త్రచికిత్స(లు) / ప్రొసీజర్ అంగీకరిస్తున్నాను. (టెక్నికల్ పదాలు వాడవద్దు మరియు ఖాళీ స్థలం వదిలివేయకండి)

1 ....

2 ....

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

1. క్లినికల్ పరిశీలనలు మరియు/లేదా చేసిన పరీక్షల ఆధారంగా, ఈ శస్త్రచికిత్స / ప్రొసీజర్ అవసరం మరియు ప్రయోజనాల గురించి నాకు వివరించబడింది.
2. ఈ శస్త్రచికిత్స / ప్రొసీజర్‌కు సంబంధించిన ప్రయోజనాలు మరియు ప్రమాదాలు నాకు స్పష్టంగా వివరించబడ్డాయి.
   ఈ శస్త్రచికిత్స / ప్రొసీజర్‌కు ఉన్న ప్రత్యామ్నాయాల గురించి, వాటి ప్రయోజనాలు మరియు నష్టాలు నాకు వివరించబడ్డాయి.

శస్త్రచికిత్స / ప్రొసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రొసీజర్ ప్రత్యామ్నాయాలు

3. ఏదైనా శస్త్రచికిత్స / ప్రొసీజర్లోలాగానే, రక్తస్రావం, ఇన్ఫెక్షన్, గుండె ఆగిపోవడం, అనస్థీషియా వల్ల అలెర్జీ, పక్షవాతం, డీప్ వెయిన్ థ్రాంబోసిస్ (DVT), పల్మనరీ థ్రోంబోఎంబోలిజం (PTE) వంటి ప్రమాదాలు సంభవించే అవకాశం ఉందని నాకు తెలుసు. అందువల్ల, పై శస్త్రచికిత్స / ప్రొసీజర్కు నేను ఇచ్చే అనుమతితో పాటు, పై పేర్కొన్న సమస్యలు లేదా అనుకోని పరిస్థితులు ఏర్పడినపుడు, రోగి/నా కోసం అవసరమని వైద్యుడు భావించే ఇతర చికిత్సలను చేయడానికి కూడా నేను అనుమతిస్తున్నాను.

అదనంగా, ఈ శస్త్రచికిత్స / ప్రొసీజర్ వల్ల సంభవించగల ఇతర సమస్యలు కూడా నాకు వివరించబడ్డాయి:

a.

b.

1. 4. డాక్టర్ ________________________________ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికిత్స / ప్రొసీజర్‌ను చేయడానికి నేను అనుమతిస్తున్నాను.
5. వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళ కూడా అని నేను అంగీకరిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రొసీజర్ ఫలితం గానీ, విజయావకాశం గానీ ఏ గ్యారంటీ ఇవ్వలేమని నేను అర్థం చేసుకున్నాను.
6. పై వివరాలన్నీ నాకు పూర్తిగా అర్థమయ్యాయి. నాకు సందేహాలు అడగడానికి అవకాశం ఇచ్చారు, మరియు అవన్నీ నాకు అర్థమయ్యే భాష సమాధానం ఇచ్చారు.
   ఈ అనుమతిని నేను పూర్తి జ్ఞానస్థితిలో, స్వచ్ఛందంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం: ....

పేరు: ....

రోగితో సంబంధం: ....

తేదీ & సమయం: ....

సాక్షి:

సంతకం: ....

పేరు: ....

తేదీ & సమయం: ....

డాక్టర్ :

సంతకం: .... పేరు: .... తేదీ & సమయం: ....

RCWH.0000254765 IP5-00174421
Master PRIYANSHU BOSE
14-07-2013 12 Y 10 M 14 D (M)
Dr. HARISH JAYARAM

Rainbow® Children's Hospital
It takes a lot to treat the little.

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DRUG CHART

Date of Admission: 28/5/26 Drug Allergies: .... ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

GENERAL - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.

DOCTOR
- Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line / through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES
- Nurses must follow strictly the FIVE RIGHTS before administration of medication.
  1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG :				Date ▸ / Time ▾
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

DRUG :				Date ▸ / Time ▾
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

DRUG :				Date ▸ / Time ▾
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

VERIFIED BY : Name .... Signature ....

RCWH.0000254765 IP5-00174421
Master PRIYANSHU BOSE
14-07-2013 12 Y 10 M 14 D (M)
Dr. HARISH JAYARAM

REGULAR PRESCRIPTIONS

Weight. 54.4 Kg Ward. E2

				Date ▸ / Time ▾
Dose	Route	Frequency	Start Date	

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : T. PARACETAMOL

Dose	Route	Frequency	Start Date	Date ▸ / Time ▾
500mg	P.O	Q8H	28/5/26	

Name & Signature of the Doctor Starting the Drugs:
Dr. Palak

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date	Date ▸ / Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date	Date ▸ / Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

RCWH.0000254765 IP5-00174421
Master PRIYANSHU BOSE
14-07-2013 12 Y 10 M 14 D (M)
Dr. HARISH JAYARAM

Weight. 54.77kg Ward. EP

DRUG :

Route	Start Date

Name & Signature of the Doctor

Additional Instructions:

Date▸ Time▾		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

VARIABLE DOSE

DRUG :

Route	Start Date

Name & Signature of the Doctor

Additional Instructions:

Date▸ Time▾		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
	Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
28/5/26	8:43 AM	Inj: CEFAZOLIN	1 gm over 30 mins prior to procedure	IV	Sai	Teena Kamala
28/5/26	9:45AM	INJ. PARACETAMOL	800 MG	IV	[signature]	Shan Kavak

VERIFIED BY : Name .... Signature ....

RCWH.0000254765 IP5-00174421
Master PRIYANSHU BOSE
14-07-2013 12 Y 10 M 14 D (M)
Dr. HARISH JAYARAM

I.V. FLUIDS CHART

Weight. 54.7 kg Ward. Ella

		...osition of I.V. Fluid (...ention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
28/5/26		IVF. DNS	IV	80ml/hr	Sai	[signature] / 800	Not connected		[signature] / [signature]
28/5	9:30AM	RINGER LACTATE	IV	500	[signature]	[signature] / [signature]	28/5	[signature]	[signature] / [signature]

VERIFIED BY : Name .... Signature ....

Rainbow® Children's Hospital
It takes a lot to treat the little.

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

RESULT SHEET

Date							
Time							
Hb							
PCV							
RBC							
WBC							
N/L							
Platelets							
CRP							
ESR							
PCT							
RBS							
Na							
K							
Cl							
Ca/Mg							
Phosphate							
Urea							
Creatinine							
ALP							
SGPT							
SGOT							
T.Bill/Conj							
T.Protein							
S.Albumin							
S.Globulin							
A/G Ratio							
Uric Acid							
S.Amylase							
Sr.Lipase							
Blood Lactate							
S.Cholesterol							
PT/INR							
APTT							
CSF Protein / Sugar							
Cells							
N/L							

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : ....

....

....

....

Radiology : USG : ....

X-Ray : ....

ECHO : ....

CT : ....

MRI ....

Others (ECG, Contrast Studies etc.,) : ....

RCWH.0000254765 IP5-00174421
Master PRIYANSHU BOSE
14-07-2013 12 Y 10 M 14 D (M)
Dr. HARISH JAYARAM

Rainbow® Children's Hospital
It takes a lot to treat the little.

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

FLUID CHART

Sheet No. : 0 28/5

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

Date	Time	Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am									—		
	09:00 am	RL	NPO	500ml	—	—	—	—	—	—	0	[signature]
	10:00 am	R	NPO	500ml	—	—	—	—	—	—	0	[signature]
	11:00 am	H2O	50ml									
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						

Total 24 hrs. Intake	

Total 24 hrs. Output	

RCWH.0000254765 IP5-00174421
Master PRIYANSHU BOSE
14-07-2013 12 Y 10 M 14 D (M)
Dr. HARISH JAYARAM

FLUID CHART

Rainbow® Children's Hospital
It takes a lot to treat the little.

Birthright
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Sheet No. : ....

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
3. 24 hrs. total to be entered in the kardex in RED.

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake	

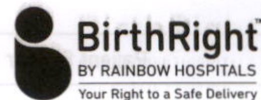
Total 24 hrs. Output	

Docu. No. : RCHBH/FRM/CLINICAL/092

SINGLE KIDNEY

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION



Name: MASTER PRIYANSHU BOSE Age: 12 Y 9 M Sex: M UHID.No : RCWHC000254765

Date: 27/5/26 Time: 3:32 Proposed Operation: EXCISION OF MUCOSAL PROLAPSE

Diagnosis: HIGH ANORECTAL MALFORMATION

B.P / CRT: <3sec H.R: 68/min Weight: 51.57 168cm ASA Physical Status: ☑1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

Hgb: 13.7	Glucose:	Protein:	HIV:	X-Ray:
PCV: 42.6	Urea:	Alb:	HBS Ag:	ECG:
WBC: 9.22	Creat:	Total Bill:	HCV:	2D Echo: Mild VSD at birth echo.
Plate: 3.61 lakh	Na:	Dir. Bill:	Blood group:	Stress/Anglo:
PT:	K:	LDH:	T3	Other:
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl -:	SGOT/SGPT:		

Allergies: No known allergy

Medical History: CVS : —

RESP : — Diabetes : —

CNS : —

Renal : SINGLE KIDNEY Left kidney Not visualised

Hepatic / GE : constant bleeding PR. Soiling from stools due to inadequate anal canal approximation. Physical Activity:

Others : —

Past Anaesthetic History: COLOSTOMY JULY 2013, PSARP 27/12/14, ADENOTONSILLECTOMY 2020 } underwent GA comfortable

Physical Exam:

Airway: MP 1 (2) 3 4 Mouth Opening: Adequate Mentohyoid Distance: (N) Neck: (N) Teeth: No loose teeth.

Lungs : AEBE

Heart: S1 S2

CNS: NAD

Pregnant: ☐ Yes ☐ No ☑ NA Venous Access Site : LUL RUL Spine Exam for regional : (N) SPACES WELL FELT.

Anaesthetic Plan: ☐ MAC ☐ REGIONAL ☑ GA-ETT ☐ LMA

Peri-Operative Plan Explained to the Patient: ☑ Yes ☐ No

CURRENT MEDICATIONS	DOSAGE
—	—
—	
—	—

Pre-Operative Instructions:

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours 1 COCONUT WATER; → Others 6 Hours 1 FOOD / MILK.
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☐ Discussed with Patient
5. Other Instructions:

→ CBC, IV cannulation

→ ~~INR~~: if Hb<9 inform Anaesthesiologist.

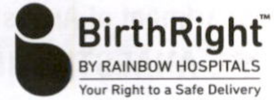
Signature: [signature] Name: Dr. ADITI NEWASKAR

Docu. No. : RCHBH /FRM / CLINICAL / 044

RCWH.0000254765 IP5-00174421
Master PRIYANSHU BOSE
14-07-2013 12 Y 10 M 14 D (M)
Dr. HARISH JAYARAM

ANAESTHESIA CHART

Rainbow® Children's Hospital
It takes a lot to treat the little.



BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No	Fasting Status: Confirmed
Physical Status: ☑ Patient Identified	☑ Consent Present ☑ Chart Reviewed

H.R: 100	B.P / CRT: 110/60	SpO_2: 98% RA	R.R: 18/min	Last Feed: >6 hrs

Pre-OP Diagnosis: Mucosal prolapse .... Operation: Mucosal prolapse excision .... Date: 27/5/26

Surgeon: Dr. Harish Jayaram .... Anaesthesiologist: Dr. [illegible]/Dr. Durgashree Technician: Nishanth

TIME	9:30 AM	to	10:30 AM
N_2O/AIR/O_2 LPM	50% →		
HALO/SO/SEVO	4% →		
Drugs:			
MIDAZOLAM	2mg iv		
PROPOFOL	40mg iv		
FENTANYL	100mcg iv		
PARACETAMOL	800mg iv		
FIO_2 / SaO_2	97/99%	99%	
$ETCO_2$		36	
ECG	NSR	NSR	NSR
Temperature	—	36.5	—
Urine Output			
Fluids / Blood	RL @ 500 ml/hr		

Antibiotic

Suppository

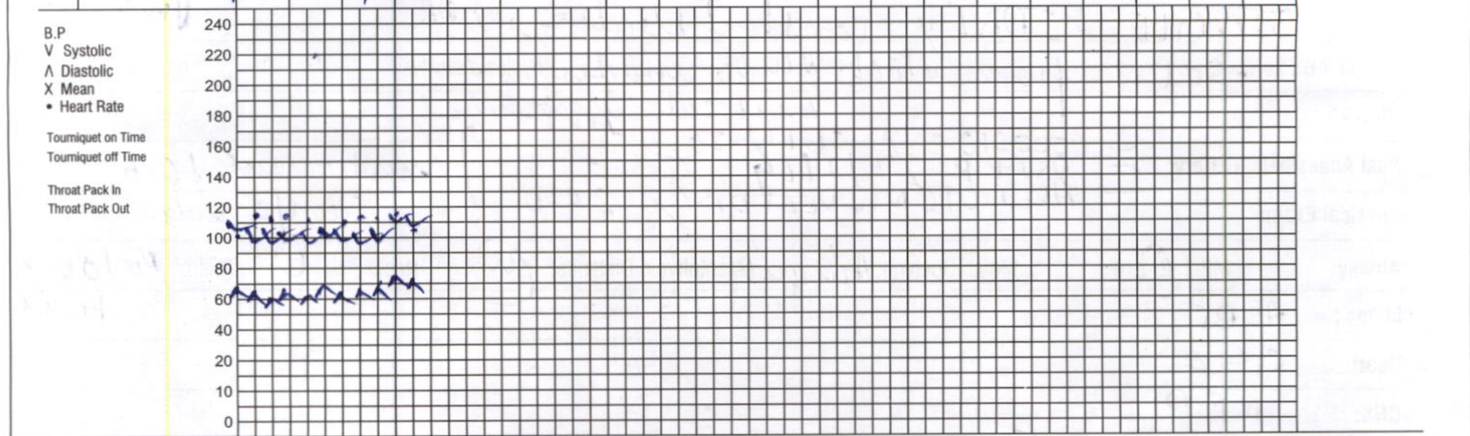
Blood Loss

NOTES

B.P
V Systolic
Λ Diastolic
X Mean
• Heart Rate

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out



LAB Values
ABG
GRBS
Others

☑ Equipment Checked and Functional
☑ BP
☑ Cuff Site: Rt LL
☐ Art Site: ....
☑ EKG Lead 3 lead
☑ Temp Site Axilla
☑ FIO_2 Monitor
☑ Agent Monitor
☑ Pulse Oximeter
☑ Capnograph
☑ Ventilator
☐ Nerve Stimulator

Position: Lithotomy
☑ Pressure Points Checked

Eye Care:
☐ Oint
☑ Tape
☐ Padding
☐ Awake

Temp:
☐ HME ☐ Fluid Warmer
☐ Cling Film ☐ OH Warmer
☑ Hugger's ☐ Cotton Wool
☐ Other

Times:
Anaes Start: 9:30 AM
OP Start: 9:45 AM
OP End: ↓
Leave OR: 10:10 AM

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP: ....
☐ ART: ....
☑ IV: Lt L
☐ IV: ....
☐ IV: ....

Induction
☑ IV ☑ Inhal
☐ Pre O_2 ☐ RSI
☐ Others

☐ Mask ☑ SGA 4.0
☐ Airway ☐ Oral ☐ Nasal
ETT# .... at .... cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug: ....

☐ Awake ☐ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# .... Attempts: ....
Difficulty Why? ....

☑ **Bilat = BS**
☐ Semi-Closed Circle
☑ Closed Circle
☐ Other

Regional:
Extremity Specify: ....
☐ Spinal ☐ Epidural ☐ Caudal
Others: ....
Position: ....
Site: ....
Needle Size: .... Depth: ....
Parasthesia ☐ Yes ☐ No
Catheter at skin .... cm
Drug Name & Conc: ....
Bolus: ....
Infusion: ....
Block Level: ....
Comments: ....

Transportation to
☑ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☑ NA

Name of the Doctor: Dr. Durgashree
Signature of the Doctor: [signature]

RCWH.0000254765 IP5-00174421
Master PRIYANSHU BOSE
14-07-2013 12 Y 10 M 14 D (M)
Dr. HARISH JAYARAM

Rainbow® Children's Hospital — It takes a lot to treat the little.

BirthRight™ BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : [signature] Time Received : 10.20 AM Time Discharged : 11 am

IV Cannula Site : 22 G

- ☐ O2 Mask
- ☐ Nasal Prongs
- ☐ Tracheostomy
- ☐ T-Piece
- ☐ Oral Airway
- ☐ Nasal Airway

	Yes	No
Vomiting :	☐	☑
NG Tube :	☐	☑
Drain:	☐	☑
Urinary Catheter:	☐	☑
Chest Tube:	☐	☑
Nil Oral	☐	☑

Drug: ....

IV Fluids: Nil

Oral Feeds: Allowed

Chart: ✓ RESP • PULSE > < BLOOD PRESSURE (0–250)

SPO2: 100% 100% 100%

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	30	60	90	OUT
Able to move 4 extremities voluntary or on command Able to move 2 extremities voluntary or on command Able to move 0 extremities voluntary or on command	= 2 = 1 = 0	ACTIVITY	1	1	2		
Able to deep breathe & cough freely Dyspnea or limited breathing Apneic	= 2 = 1 = 0	RESPIRATION	2	2	2		
BP ± 20 of Pre Anaesthetic leve BP ± 20-50 of Pre Anaesthetic leve BP ± 50 of Pre Anaesthetic leve	= 2 = 1 = 0	CIRCULATION	1	2	2		
Fully awake Arousable on calling Not responding	= 2 = 1 = 0	CONSCIOUSNESS	2	2	2		
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0	COLOR	2	2	2		
		TOTAL	8	9	10		

SCORING INTERPRETATION

A Minimum Total Score of 8 is Required for Discharge

Exceptions to this, are to be explained in the space below by the Discharging Physician:

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
28/5	11:10 am	02/10	NA	[signature]

Pain Tool Used: ☐ N PASS ☐ FLACC ☑ Wong Baker ☐ NPS

Anaesthesiologist Name : Dr. Durga Bhav[illegible]

Anaesthesiologist Signature: [signature]

Date & Time: 28/5/26 at 11:23 am

PACU Nurse Name : [signature]

PACU Nurse Signature: [signature]

Date & Time: 28/5/26 at 11:30 am

Reassessment Frequency:

1. Every eight hours for all hospitalized patients.
2. For post surgical patient, patient with chronic pain, patient with severe pain
   a. Every 2 hours for first 24 hours
   b. After 24 hours every 4 hours
   c. Prior to pain reliving intervention
   d. With in 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU): Day Care

Date & Time: 28/5/26 at 11:30 am

Patient Sticker

Rainbow® Children's Hospital
It takes a lot to treat the little.

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: .... Time: .... Procedure done by ....

CSE /Spinal /Epidural Position : .... Space :................................ Technique (LOR/LOS) ....

Depth: .... Catheter at Skin: .... Attempts : ....

Parasthesia : Yes/No if yes details : ....

Solution Composition : ....

Any other issues :

a) ....

b) ....

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level Left	Level Right	Maternal BP	Maternal Pulse	FHR	Comments

Delivery Details : Time : .... APGAR: .... SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected : ....

Patient Satisfaction : ....

Discharge /Shifting ordered by

Doctor Signature: ....

Doctor Name: ....

Date and Time : ....

RCWH.0000254765 IP5-00174421
Master PRIYANSHU BOSE
14-07-2013 12 Y 10 M 14 D (M)
Dr. HARISH JAYARAM

Rainbow® Children's Hospital
It takes a lot to treat the little.

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

CONSENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☑ Patient Attendant

Operative Procedure: EXCISION OF MUCOSAL PROLAPSE

Anaesthesiologist: Dr. Aditi - Surgeon: Dr HARISH J M

Please read this before you consent for Anaesthesia

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief can be achieved by infusing weak solutions of local anaesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk(s): The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders

☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease

☐ Others DESATURATION, POST OP O2 requirement.

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team

  ☐ Regional Anaesthesia ☑ General Anaesthesia ☐ Monitored Anaesthesia Care

- I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: Mousumi Bose

Name: Mousumi Bose

Relationship with patient: Mother

Date & Time: 27/5/21 3:44 pm.

Witness:

Signature: [signature]

Name: AMIT BOSE

Date & Time: 27/5/21 3.44 pm.

Doctor (who is taking consent):

Signature: Aditi Name: Dr. Aditi V Date 27/5/21 Time: 3.44 pm

Docu. No.: RCHBH / FRM / CLINICAL / 021

(P.T.O)

Patient Sticker

Rainbow Children's Hospital
It takes a lot to treat the little.

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స: ....

అనస్థీషియా వైద్యుడు: .... శస్త్రచికిత్స నిపుణుడు: ....

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

సాధారణ అనస్థీషియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అపస్మారక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్రావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు. రీజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్కోటిక్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై రిస్క్:

క్రింద పేర్కొన్న వైద్య సమస్యల కారణంగా ఉండే అధిక ప్రమాదాల గురించి వైద్యులు నాకు వివరంగా చెప్పారు. నాకు ఉన్న సందేహాలను నేను అడిగాను మరియు అవి నివృత్తి చేయబడ్డాయి.

☐ హృదయ వ్యాధి ☐ రక్తపోటు ☐ మధుమేహం ☐ మూత్రపిండాల వైఫల్యం ☐ బహుళ అవయవ వైఫల్యం

☐ కాలేయ సమస్యలు ☐ షాక్ ☐ ఊబకాయం ☐ దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)

☐ ఇతరవి: ....

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
  ☐ రీజనల్ అనస్థీషియా ☐ జనరల్ అనస్థీషియా ☐ మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజెక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జీ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెనస్ యాక్సెస్, ఆర్టీరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, రీజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీషియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను అంగీకరిస్తున్నాను.
- పై సమాచారం అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో వాటికి సమాధానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్పష్టమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:	సాక్షి:
సంతకం:	సంతకం: ....
పేరు:	పేరు: ....
రోగితో సంబంధం:	తేదీ & సమయం: ....
తేదీ & సమయం:	

డాక్టర్ :

సంతకం: .... పేరు: .... తేదీ & సమయం: ....

Docu. No. : RCHBH / FRM / CLINICAL / 021

(P.T.O)

RCWH.0000254765 IP5-00174421
Master PRIYANSHU BOSE
14-07-2013 12 Y 10 M 14 D (M)
Dr. HARISH JAYARAM

Nursing General Admission Assessment Form For Pediatrics

Diagnosis:

Arrival Time: 8.15 am Mode of Arrival: walking Admitting From: ☑ ER ☐ OPD ☐ Direct

Allergy / Adverse Reaction NKDA Body Weight: 55 Kg

Height: — cm

Past Medical History: Obtained From ☐ Patient ☑ Family Member ☐ Medical Record ☐ Other (specify) ....

Past Medical History	Past Surgical History	Previous Hospital Admission
Single kidney NA	Colostomy July 2013 Adeno 2020	Colostomy 2013 July Adeno 2020

Family History: Nothing significant

Has the child or close family member had recent contact with a communicable disease? ☐ Yes ☑ No

If yes please list, —

Was the child's birth normal? ☑ Yes ☐ No If No, please describe problems: —

Are the child's immunization up to date? ☑ Yes ☐ No

Current Medication: ☑ None ☐ Yes, If Yes, fill reconciliation form

Observations: Weight: 55 kg Length: — Head Circumference (< 2 years): —

Temp.: 98.4°F HR: 82 b/m RR: 26 b/m BP: 90/60 mmHg

Pain Score: 0/10 Specify Site: — (Follow Pain Assessment Sheet & Document)

Fall Risk Assessment: ☑ Yes ☐ No Score: 10 (Document in the Humpty Dumpty Sheet)

Risk of Pressure Sore (Braden Q Score 26) (Document in the Braden Q Assessment Sheet)

Pain Screening: ☑ Yes ☐ No If Yes, Pain Score: 0/10 Pain Tool Used: ☐ N Pass ☐ FLACC ☑ Wong Baker

Character of Pain — Location — Frequency — Duration —

FUNCTIONAL SCREENING: ☑ No Abnormalities Detected

☐ Mobility Problem ☐ Walking Problem
☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☑ No Abnormalities Detected

☐ Underweight ☐ Overweight ☐ Special Feeding Method
☐ Feeding Problem ☐ Special diet ☐ No Abnormality Detected

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

Unusual concerns about patient's Psychological Status: ☐ Yes ☐ No

If Yes Consultant Notified: ....— .... (Date/Time): ....—........

Cultural & Spiritual Needs: ☐ Yes ☑ No if Yes specify ....—........ Inform consultant for positive criteria.

Social History: Lives With ....Parent........

Siblings in household ☐ Yes ☐ No (if yes How Many?) ....

All Information Obtained From ☐ Patient ☑ Mother ☐ Father ☐ Other Family Member

Orientation has been given regarding the following aspects:

Call Bell in Reach : ☑ Yes ☐ No Waste Disposal Explained: ☑ Yes ☐ No

Infusion Pump : ☑ Yes ☐ No Hand hygiene Explained: ☑ Yes ☐ No ☐ Others

Patient Rights & Responsibilities: ☑ Yes ☐ No

Information given to ....Father........

Nurse Signature: ....[signature]........

Nurse Name: ....Teena........

Date: ....28/5/26........

Time: ....8:20 am........